HEALTH INSURANCE INFORMATION DCSS 0054 (04/27/05)

ounty: PLACER Phone:			LC	LCSA Case Number:						
loncustodial Parent:										
Full Name (First, Middle, Last, Suffix)			☐ Cust	l am the						
Address (Street)			City, Sta	City, State, Zip Code						
Phone			Social Security Number							
Employer (Name, street, city, state	e, zip code, phone	9)								
the completed	about the other form.	parent's insur	nce is provided ance. Employe	f or available by rs complete Sec	the Noncustotions I and III	odial Parent or e only. Please sig	employer. In and date			
SECTION I: YOUR HEAL	TH INSURAN	CE								
HEALTH INSURANCE:										
Do you currently have Health Insu					e complete the	following.				
Health Insurance Company or Un	´	Provided by: Custodial Party Employer Relationship:								
Insurance Company's Address: S (Address where claims are mailed City State		Number or Unit	Number	ļ F	olicy Number	Telephone Num (include Area C				
Premium Amount \$	···	Check One:	☐ Weekly	☐ Bi-Week	ıv ns	emi-Monthly				
Amount You Pay \$			Weekly	Bi-Week		emi-Monthly				
		Check One:			,	Semi-Monthly				
Amount Employer Pays \$										
Amount of deduction applied to employee's portion of Health Insurance \$		Amount of deduction applied to dependent's portion of Cost to add additional child Health Insurance \$								
Dependent(s) Currently Cov	ered By Healt	h Insurance								
Name (First, Middle, Last)	Social Secur Number	ity Se	Date of Birt	n Policy Nu	mber(s)	Start Date	End Date			
1.					-					
2.										
3.		1-1-1					·			
4.		-								
5.										
6.										
Please check this box if name separate sheet. Please attack. Not available to dependents.	es and policy num in the sheet.	nbers of addition	nal dependents	covered by your	Health Insuran	ce are listed on a	3			

The Policy covers the follo		heck all that apply) care Supplemental	Specific Illness			Prescription Drugs					
Long Term Care	☐ Hosp	oital Stays	□	łospital O e., <i>lab wo</i>	utpatient rk, physic	cal therapy		ner (Sp	ecify):		
DENTAL INSURANCE	:										
Do you currently have De	ntal Insur	ance coverage?	Yes	☐ No		If Yes, ple	ease complete	the fo	llowing.		
Dental Insurance Compar	ıy										
Dental Insurance Compar	ıy's Addr	ess: Street, Apartme	nt Numbe	er or Unit i	Number (address w	here claims a	re mail	ed)		
Dity	Sta	ite	Zip Ci	ode			P	olicy N	umber		
Premium Amount \$			Check One: Weekly						Semi-Mont	hly	
Amount You Pay \$			Check One: Weekly					Semi-Monthly			
Amount Employer Pays \$			Check One: Weekly					Semi-Monthly			
Amount of deduction application of Health Insurance		iployee's	Amount of deduction applipartion of health insurance						ost to add additional child		
Dependent(s) Covere		ental Insurance	portion	i oi neatti	msuranc	c u	· · ·	1Ψ			
Name (First, Middle, Last		Social Security Number	Sex	Date of	Birth	Policy N	umber(s)	S	tart Date	End Date	
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2.											
3.		·	-					\dashv			
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5.							-				
S											
Please check this box separate sheet of pap Not available to deper VISION INSURANCE. Do you currently have Vivision Insurance Comparate the Note of th	er. Pleas ndents sion Insu ny	rance coverage?	Yes	□ No	lf Y	'es, pleas	e complete th	e follow	ring.	. a	
Vision Insurance Compa	ny's Addr	ess: Street, Apartme	nt Numbe	er or Unit i	Number (Address v	vhere claims a	ere mai	led)		
City State		Zip Code			Policy Number			ſ			
Premium Amount \$			Check (One:	Weekly		Bi-Weekly		Semi-Month	ıly	
Amount You Pay \$			Check (Weekly		Bi-Weekly		Semi-Month	ily	
Amount Employer Pays			Check (Bi-Weekly		Semi-Month		
Amount of deduction app portion of Health Insuran				deduction surance \$		o depende	ent's portion	Cost I	to add addilior	nal child	
Dependent(s) Cover					 	T 5	1		Ohand Darks	T 6-4 6-4-	
Name (First, Middle, Las	t)	Social Security Number	Sex	Date of	f Birth	Policy !	Number(s)	:	Start Date	End Date	
1.			<u> </u>			<u></u>			·	-	
3.				ļ		· .	· · · · · · · · · · · · · · · · · · ·				
4.		-				<u> </u>				-	
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		<u> </u>			 	1	· · -		12 : 2		
Please check this bo separate sheet. Plea Not available to depe	se attach		s of additi	onal depe	ndents c	overed by	your Vision Ir	surano	e are listed or	ı a	

SECTION III. OTHER BARE	NT'S INSTIDANCE	
SECTION II: OTHER PARE	INT'S INSURANCE	
HEALTH INSURANCE: Does the other parent currently If Yes, please complete the folio	provide Health Insurance coverage for wing information.	the child(ren) or you? Yes No
lealth Insurance Company		
Health insurance Company's Ac	ldress: Street, Apartment Number or L	init Number (Address where claims are mailed)
City	State	Zip Code
DENTAL INSURANCE: Does the other parent currently f Yes, please complete the follo Dental Insurance Company	provide Dental Insurance coverage for wing information.	the child(ren) or you?
• •	ddress: Street, Apartment Number or U	Init Number (Address where claims are mailed)
City	State	Zip Code
VISION INSURANCE: Does the other parent currently If Yes, please complete the followision Insurance Company	provide Vision Insurance coverage for owing information.	the child(ren) or you?
Vision Insurance Company's A	ddress: Street, Apartment Number or U	Jnit Number (Address where claims are mailed)
City	State	Zip Code
SECTION III: (MUST BE C	OMPLETED)	
		rage for the child(ren). ne coverage for the child(ren). I will send the information to you when I get
At this time there is no hea	Ifh insurance coverage available. Tun	derstand that if it becomes available, I will have to add my child(ren) onto erage. Coverage is unavailable because:
☐ Not offered ☐ Season	nal Part-Time Refused enro	Ilment Unreasonable in cost Probationary period/date eligible
	PRI\	ACY STATEMENT
provided when collecting person Department of Child Support 9	onal information from individuals. Inforr services (DCSS) for purposes of identif act, to collect the Social Security Numb	nd the Federal Privacy Act of 1974 (Public Law 93-579) require this notice be nation requested on this form, including Social Security Number, is used by the ication and communication with you. The DCSS is required, under Section 466 er of any individual who is subject to a divorce decree, support order, or paternity
accate for the nurnice of ecta	blishing modifying and enforcing child	file at the local child support agency to locate and identify individuals and support obligations. Enrolling a child in health insurance may require the the other parent's employer or the release of the child's Social Security
The information in your case rother parent or his/her attorned	may be discussed with or given to the sy to the extent required by law.	State, other agencies that can legally receive such information, and to the
SIGNATURE		DATE
PRINTED NAME	<u> </u>	TELEPHONE (include Area Code)
FIXINGED NAME		TEEL HOME (Molado / Mal a a a a a a a a a a a a a a a a a a